

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04600

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred: Detmold Street
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Detmold
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Elizabeth H Anderson

3. (b) Social Security Number

-

4. Sex Female 5. Color of face White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife James Anderson

6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 5 1861

8. AGE: Years 85 Months 11 Days 9 If less than one day - hrs. - min.

9. Birthplace Monrovia, Pa
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name Holbaugh

13. Birthplace Pennsylvania

14. Maiden name Unknown

15. Birthplace "

16. Informant Alexander Anderson

Address Lonaconing, Md

17. Burial Burial Date thereof June 17 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow

18. Funeral director Mr. Eichhorn

Address Lonaconing, Md.

19. June 17 1947 Registrar James M. Boal

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 19 47 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 19 47 to June 14 19 47

and that I last saw him alive on June 13 19 47

Immediate cause of death Cerebral Hemorrhage

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

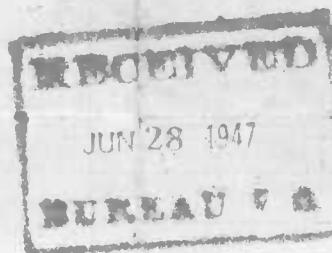
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury - Injured at work? -

23. SIGNATURE Henry D. Hodgson M.D.

Address Lonaconing, Md. Date signed June 17 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

04601

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77Yrs.
Hospital, institution, or street address where death occurred:
208 Beall St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 Beall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Henry James Bergman

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Sarah Long Bergman 6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Feb. 23, 1870
8. AGE: Years 77 Months 3 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Kelly Tire Co.
FATHER 12. Name James Bergman
13. Birthplace Germany
MOTHER 14. Maiden name Sarah Bishop
15. Birthplace Maryland

16. Informant Edward C. Bergman
Address 11 Grand Ave. Cumberland, Md.
17. Burial Burial Date thereof June 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory S.S. Peter & Paul
Cumberland, Md.
Location Charles L. George
18. Funeral director Charles L. George
Address Cumberland, Md.

19. June 14 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947 at 12:15A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1947 to June 13, 1947
and that I last saw him alive on June 5, 1947

Immediate cause of death Coronary Artery Disease DURATION 24L

Due to Arterio Sclerosis

Due to Arterio Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. P. Franklin, M.D. M. D. or other

Address Cumberland Date signed June 14, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 18 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

04602

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 3 1/2 days

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? about 3 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Flintstone
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James W. Blizzard

3. (b) Social Security Number

None4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Esther Blizzard6. (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) Jan. 14, 18788. AGE: Year 69 Months 4 Days 26 It less than one day _____ hrs. _____ min.9. Birthplace Keyser, Mineral Co, West Virginia
(Town, county, and state)10. Usual occupation Retired Foreman11. Industry or business Md State Roads Commission12. Name Jesse Blizzard13. Birthplace Keyser, W. Va14. Maiden name Delilah Elbin15. Birthplace Keyser, W. Va.16. Informant Mrs James W. BlizzardAddress Flintstone, Md.17. Burial Date thereof 6/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glendale CemeteryLocation Flintstone, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. June 13, 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him in bed June 10, 1947Immediate cause of death Traumatic contusion of skull & dislocation of the 5th cervical vertebrae with DURATION about 3 1/2***interruption of spinal cord days& quadriplegia due to a fall*** from 2nd floor of buildingto ground.Other conditions abrasion of chin &laceration, palm of rt. hand.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6.6.1947Where did injury occur? Gilpentown Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) near homeMeans of injury erecting building injured at work? yes& accidentally fell from 2nd floor.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or O. D.Address Cumberland Md Date signed 6-10-47

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JUN 18 1947

BUREAU V C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

Reg. Dist. No. 04603 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 2 1/2 months
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 11 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 402 Furnace St.
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Rose Belle Bach

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 20, 1893

8. AGE: Years 53 Months 7 Days 23 It less than one day
 hrs. min.

9. Birthplace Cumberland, Allegheny Co., Md.
(Town, county, and state)10. Usual occupation Teamster11. Industry or business Retail ClothingFATHER 12. Name George Bach13. Birthplace Allegheny Co., Md.MOTHER 14. Maiden name Barbara O'Baker15. Birthplace Allegheny Co., Md.16. Informant Edward BachAddress 430 Valley St., Cumberland, Maryland17. Burial Date thereof June 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sts Peter & PaulsLocation Cumberland, Maryland18. Funeral director John J. HaferAddress Cumberland, Maryland19. June 14 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 47 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... to 19.....
 and that I last saw h ER. Deed June 13 19 47

Immediate cause of death Unsubstantiated
confluent Broncho-Pneumonia DURATION about 8 weeks

Due to Fracture of the left femur 2 1/2
months

Due to a fall on slipping kitchen floor

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-30-1947

Where did injury occur? Cumberland Allegheny Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) homeMeans of injury Slipping on floor Injured at work? N.

Deputy Medical Examiner Allegany Co.
H. V. Deming M.D.

23. SIGNATURE..... M. D. or other

Address Cumberland, Md. Date signed 6-14-47

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JUN 18 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04604

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 Years
 Hospital, institution, or street address where death occurred:
309 Washington St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 309 Washington St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Charlotte McClellan Bowersox

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Hixon T. Bowersox6.(c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) July 30 1893

8. AGE: Years 53 Months 10 Days 1 If less than one day
hre.min.

9. Birthplace Rossville, York Co., Penna.
(Town, county, and state)10. Usual occupation House

11. Industry or business

12. Name William J. McClellan13. Birthplace Rossville, Pa14. Maiden name Emma Jane Oberdier15. Birthplace Rossville, Pa16. Informant Hixon T. BowersoxAddress 309 Washington St., Cumberland, Md.17. Burial Date thereof 6/4/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.

June 4 1947 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1947 at 4 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1947 to June 1st 1947and that I last saw him alive on June 1st 1947Immediate cause of death Acute Coronary ThrombosisDURATION few minutes

Due to

Due to

Other conditions plus Cholelithiasis - ?

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

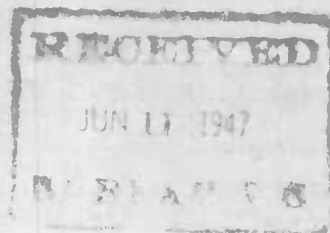
23. SIGNATURE J. P. Franklin, M.D.Address Cumberland, Md. Date signed 6-3-47

MARGIN RESERVED FOR BINDING

VS A15 9-4-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Hight



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 468
CERTIFICATE OF DEATH

04605

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County..... <u>Allegany</u> City or town..... <u>LaVale</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Allegany</u> City or town..... <u>LaVale</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Elizabeth Catherine Buchholtz</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>William Buchholtz</u>						6. (c) If alive, give age years	
7. Birth date of deceased (mo., day, yr.) <u>July 6, 1867</u>							
8. AGE: Years <u>79</u> Months <u>10</u> Days <u>25</u> hrs. min.							
9. Birthplace <u>Cincinnati, Ohio.</u> (Town, county, and state)							
10. Usual occupation <u>Housewife</u>							
11. Industry or business							
FATHER		12. Name <u>Mathias Maus</u>					
		13. Birthplace <u>Alsace Lorraine</u>					
MOTHER		14. Maiden name <u>Mary Zapf</u>					
		15. Birthplace <u>Cumberland, Md.</u>					
16. Informant <u>Mr. Vincent Buchholtz</u> Address <u>Narrows Park, Cumberland, Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>June 4, 1947</u> (month) (day) (year) Cemetery or crematory <u>S. S. Peter & Paul</u> Location <u>Cumberland, Md.</u>							
18. Funeral director <u>Charles L. George</u> Address <u>Cumberland, Md.</u>							
19. <u>June 4, 1947</u> (Date rec'd by registrar)						<u>J. P. Franklin, M.D.</u> Registrar	
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>June 1,</u> 19 <u>47</u> , at <u>4:20 P.M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 4,</u> 19 <u>47</u> , to <u>June 1,</u> 19 <u>47</u> , and that I last saw her alive on <u>May 29,</u> 19 <u>47</u>							
Immediate cause of death <u>Chronic cholecystitis with stones</u> <u>Carcinoma Liver</u>						DURATION <u>?</u> <u>?</u>	
Due to <u>Diabetes mellitus</u> <u>Hypertension</u> <u>Toxic Goitre</u>							
Other conditions (Include pregnancy within 3 months of death)							
Major findings of operations Date of op.							
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>W. A. Van Dusen, M.D.</u> M. D. or other Address..... <u>110 S. Centre St.</u> Date signed..... <u>3 June, 47</u>							

RECEIVED

JUN 11 1947

STEELE'S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

04606

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred: 173 Thomas St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 173 Thomas St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Karon Lee Cage

3.(b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 9 - 1946 6.(c) If alive, give age. years

8. AGE: Years 0 Months 5 Days 24 If less than one day hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name William F. Cage

13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Betty Jane Detrick

15. Birthplace Cumberland Md.

16. Informant Wm. F. Cage

Address 173 Thomas St., Cumberland Md.

17. Burial Date thereof June 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director Louis Stein Inc

Address Cumberland Md.

19. June 5, 47 J. P. Traubke, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 47 at 11:30 AM about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her Dead June 3 19 47

Immediate cause of death Suffocation DURATION at once

Due to a bed pillow accidentally fell down on her face as she was lying on her back in bed.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-3-47

Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury as above Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 6/3/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU U.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55

CERTIFICATE OF DEATH

Reg. Dist. No. 046074

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 30 Green St.
(If rural, give LOCATION)
2(a) If veteran, name war...

3. (a) FULL NAME

EDWARD JAMES CARDER

3. (b) Social Security Number

212-10-9260

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Virgie M. Carder
6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) September 22, 1891

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>9</u>	<u>14</u>	hrs. min.

9. Birthplace Glencoe, Somerset, Pa.
(Town, county, and state)

10. Usual occupation Stationary engineer

11. Industry or business Fire clay mines

FATHER
12. Name James Carder
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Janet Rohison
15. Birthplace Maryland

16. Informant Elmer Carder
Address Frostburg, Md.

17. Burial Date thereof June 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Michael's Cemetery
Location Frostburg, Md.

18. Funeral director J. R. Durst
Address Frostburg, Md.

19. June 9, 1947 J. P. Frankel, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 June, 1947, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 March, 1947, to 7 June, 1947
and that I last saw him June 6, 1947 alive on

Immediate cause of death
Generalized carcinomatosis,
primary source undetermined. DURATION 8 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Von Dine, M.D.
M. D. or other
Address 110 S. Centre St. Cumb. Date signed 9 June, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 18 1947

BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

Reg. Dist. No. 04608 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Weber St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Child

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

June 4, 1947

8. AGE:

Years

Months

Days

It less than one day

3 hrs. min.9. Birthplace Cumberland, Allegany Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal, Which?)

Date thereof June 6, 1947
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 6, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 47 at 11:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 19 47 to June 4 19 47and that I last saw him alive on June 4 19 47

Immediate cause of death

Intra-aortic aneurysm

DURATION

Due to Prolonged labor

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Refused request for

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

W. R. Hodge, M.D.
Address Cumberland, Md Date signed 6/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Dr. P. R. W. 104609

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
413 Hammond St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 413 Hammond St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

MAURICE JOSEPH CUMMINGS

3. (b) Social Security Number

705-07-2245

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna Carney Cummings
 6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 18, 1882
 8. AGE: Years 65 Months 3 Days 4 It less than one day hrs. min.

9. Birthplace Dunbar, Fayette, Pennsylvania
 (Town, county, and state)

10. Usual occupation Machinists Helper

11. Industry or business Railroad

FATHER 12. Name Luke Cummings
 13. Birthplace Weston, West Virginia

MOTHER 14. Maiden name Katherine McCusker
 15. Birthplace Mt Savage, Maryland

16. Informant Mrs. Anna Cummings
 Address Westernport, Maryland

17. Burial St. Peter's Cemetery Date thereof June 25, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Peter's Cemetery
 Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. June 23, 1947 (Date rec'd by registrar) Ellsworth S. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 47 at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 19 47 to June 22 19 47
 and that I last saw him alive on June 22 19 47

Immediate cause of death Embolism Coronary Artery - Angina Pectoris Hypertension
 DURATION 3 Hours 1 Year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D. M. D. or other

Address Piedmont, W. Va. Date signed June 23, 1947

RECEIVED

JUN 24 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

510 Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 510 Baltimore Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Howard Levi Deneen

3. (b) Social Security Number

705-05-7743

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Alice Mountain Deneen6. (c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) September 4, 1884

8. AGE:

Years

Months

Days

If less than one day

62925

hrs.

min.

9. Birthplace Rock Hill, Bedford Co., Pa.
(Town, county, and state)10. Usual occupation car repairman11. Industry or business B & O R R.12. Name William Deneen13. Birthplace Buck Valley, Pa14. Maiden name Candace Wigfield15. Birthplace Bedford Co., Pa.16. Informant Mrs. Alice DeneenAddress 510 Baltimore Ave, Cumberland, Md17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2, 1947
(month) (day) (year)Cemetary or crematory Pleasant Grove CemeteryLocation East of Cumberland on Rt. 4618. Funeral director John J. NafarAddress Cumberland, Md.19. Date rec'd by registrar July 1, 1947 Walter L. Taylor, M.D. Registrar
acting

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1947 to June 29, 1947and that I last saw him alive on June 28, 1947

Immediate cause of death

Exhaustion and
Carcinoma of Prostate

DURATION

2 monthsDue to Carcinoma of Prostate 1 year

Due to

Other conditions Chronic hypohid 2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

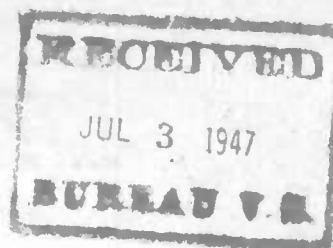
23. SIGNATURE F. Allen G. Hanna, M.D. M. D. or otherAddress Cumberland, Md. Date Signed June 20, 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04611

1. PLACE OF DEATH:

County Allegany
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
P.O. No. 2, Box 14, Frederick, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Frederick P.O. No. 2 Box 14
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Frederick, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Julia Elizabeth Leibel

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Albert Leibel

7. Birth date of deceased (mo., day, yr.) Mar. 3rd. 1878 6. (c) If alive, give age ✓ years

8. AGE: Years 69 Months 3 Days 24 If less than one day hrs. min.

9. Birthplace Salisbury, Pa.
 (Town, county and state)

10. Usual occupation Domestic

11. Industry or business

12. Name John Fritzburg

13. Birthplace Leont, Pa.

14. Maiden name Mary Buskey

15. Birthplace Leont, Pa.

16. Informant Mrs. John Little

Address P.O. No. 2 Box 14 Frederick, Md.

17. Burial Date thereof 6-28-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran

Location Frederick, Md.

18. Funeral director Jacoff & Vapir

Address Frederick, Md.

19. 6-28 19 47 Blanchette & Price
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 47 at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to June 22 19 47
 and that I last saw her alive on June 21 19 47

Immediate cause of death Chronic Myocarditis DURATION several years
Hypertension 1

Due to

Other conditions Chronic of Liver 1 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane, MD M. D. Frederick

Address Frederick, Md. Date signed June 24, 1947

RECEIVED

JUN 30 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

04612

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 years

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleghenyCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Wm. Jos. Lonahues

3. (b) Social Security Number

214-01-3674

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Agnes Stahers

7. Birth date of

deceased (mo., day, yr.)

July 25th. 18926. (c) If alive, give age 52 years

8. AGE:

Years

Months

Days

It less than one day

54824

hrs.

min.

9. Birthplace.

Frederick, Allegheny, Md.
(Town, county, and state)

10. Usual occupation

Labor Inspector

11. Industry or business

State Department

12. Name

John Lonahues

13. Birthplace

Frederick, Md.

14. Maiden name

Emma E. Lettigan

15. Birthplace

Cumberland, Md.

16. Informant

Wm. Lonahues, Jr.

Address

Frederick, Md.

17. Burial, cremation, or removal, Which?

Date thereof June 21, 1947
(month) (day) (year)

Cemetery or crematory

St. Michael's Cem.

Location

Frederick, Md.

18. Funeral director

Joseph Hafer

Address

Frederick, Md.19. 6/21 19 47
(Date rec'd by registrar)Blanchy O. Quice
acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 47 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 47 to June 19 19 47and that I last saw him alive on June 18 19 47

Immediate cause of death

Chronic Rheumatic
Heart Disease

DURATION

Several
years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Wm. Lonahues, Jr.

M. D. or other

Address Frederick, Md. Date signed 6-20-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1947

BUREAU V.S.

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04613

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Rural R. D. #2 Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. D. #2 Cumberland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural R. D. #2 Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. #2 Cumberland.

(If rural, give LOCATION)
World War #1

2.(a) If veteran, name war

3. (a) FULL NAME

Matthew Dowling Sr.

3. (b) Social Security Number

705-07-6838

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hazel Liller

7. Birth date of deceased (mo., day, yr.)

July 3, 1881

6. (c) If alive, give age 57 years

8. AGE:

Years

65

Months

10

Days

27

If less than one day

hrs.

min.

9. Birthplace

Grafton, W. Va.

(Town, county, and state)

10. Usual occupation

Retired Engineer

11. Industry or business

B. & O. Railroad

FATHER

12. Name

Matthew Dowling

13. Birthplace

Penna.

MOTHER

14. Maiden name

Lee Ann Neil

15. Birthplace

Grafton, W. Va.

16. Informant

Mrs. Hazel Dowling

Address

R. D. #2 Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 3, 1947
(month) (day) (year)

Cemetery or crematory

Philos Cem.

Location

Westernport, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19. June 3 19 47
(Date rec'd by registrar)

J. P. Fauslin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1947 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on June 1, 1947

Immediate cause of death

DURATION

Coronary Thrombosis

Due to 20 min

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

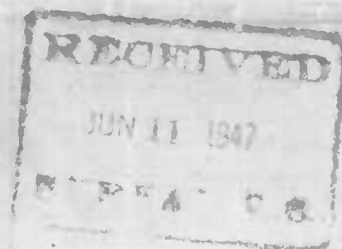
Clay Liller
Address Cumberland Date signed 6/3/47

MARGIN RESERVED FOR BINDING

9-7-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 mos 4 mo 10 da

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 GRAND AVENUE
(If rural, give LOCATION)2.(a) If veteran, name war I ST WORLD WAR

3. (a) FULL NAME

EARL DRENNING

3. (b) Social Security Number

705-05-5294

4. Sex

MALE

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife PEARL WHETZEL6.(c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) JANUARY 27, 18968. AGE: Years 51 Months 4 Days 10 It less than one day
hrs. min.9. Birthplace... MARYLAND, CUMBERLAND, ALLEGANY
(Town, county, and state)10. Usual occupation MACHINIST11. Industry or business B & O RAILROAD12. Name DRENNING, WILLIAM13. Birthplace WEST VIRGINIA14. Maiden name CARRIE HALL15. Birthplace MARYLAND16. Informant Earl Drenning Jr.Address Cumteland17. Burial Date thereof June 10 47
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumteland Ind.18. Funeral director Louis Stein IncAddress Cumteland19. June 10 47 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 47 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Cerebral Vascular DiseaseDue to Arterio SclerosisDue to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

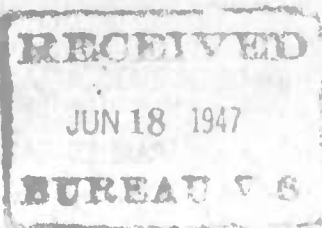
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D.Address 1267 Cumteland

Date signed



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL

How long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town LONA CONING
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SARA EILBECK

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6. (b) Name of husband or wife NICHOLSON EILBECK

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/96

8. AGE: Years Months Days If less than one day
51 0 0 hrs. min.9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name GEORGE T. LASHBAUGH

13. Birthplace MD.

14. Maiden name MARION BROWN

15. Birthplace MD.

16. Informant Nicholson Eilbeck

Address Lonaconing road

17. Burial Date thereof June 17, 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Laurel Hill Cemetery

Location Lonaconing road

18. Funeral director M. Eichhorn

Address Lonaconing road

19. June 13, 19 47 J. A. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13, 1947, at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 13, 1947, to June 13, 1947,
and that I last saw him alive on June 13, 1947.

Immediate cause of death DURATION

Gastric Hemorrhage 12 days

Due to Eroded artery in stomach ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

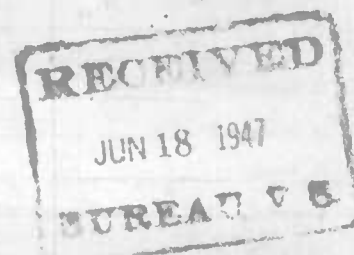
23. SIGNATURE J. A. Franklin, M. D.

Address Lonaconing road Date signed 6/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

VS A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

04616

Dr. R. Williams

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 YRS.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
603 KENT AVE.
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME
ELIZABETH
MRS. NANNIE EVANS

3. (b) Social Security Number
NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife SAMUEL EVANS 62
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) FEB. 16 1889

8. AGE: Years 58 Months 4 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace WEST VA. HAMPSHIRE CO.
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name WILLIAM LOY

13. Birthplace WEST VIRGINIA

14. Maiden name JANE SMITH

15. Birthplace WEST VIRGINIA

16. Informant Samuel Evans

Address Cumberland Ind

17. Burial Date thereof June 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland Ind.

18. Funeral director Louis Stein Inc.

Address Cumberland

June 23, 1947 White R. Frantz, M.D.
(Date rec'd by registrar) Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 21, 1947 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/18/47 to 6/21/47 and that I last saw her alive on 6/21/47

Immediate cause of death Uremia

Due to Chr Nephritis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

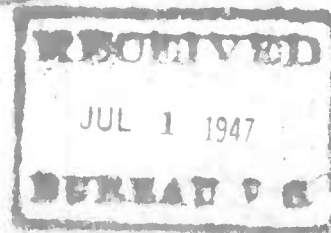
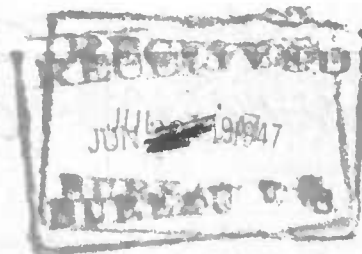
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. Williams, M.D.

Address Cumberland Date signed 6/21/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04617

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 15 hrs. 20 min

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 day 15 hrs. 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 320 DORN AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

FAGAN BABY GIRL

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-47

8. AGE: Years Months Days If less than one day
1 15 hrs. 20 min.9. Birthplace CUMBERLAND ALLEGANY MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name WILLIAM FAGAN

13. Birthplace VIRGINIA

14. Maiden name BETTY LUTTRELL

15. Birthplace MD.

16. Informant Mr. William Fagan

Address 320 Dorn Ave. Cumberland, Md.

17. Burial Date thereof June 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. June 4, 1947 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947 at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947 to June 2, 1947

and that I last saw him alive on June 2, 1947

Immediate cause of death DURATION

Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Date signed

RECEIVED

JUN 11 1947

BUREAU V K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

CERTIFICATE OF DEATH

Dr P E Berry

Reg. Diat. No. 04618

1. PLACE OF DEATH:

County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred:
90 Mullen Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 90 Mullen Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Virginia
Maxine XXXXXXXX Funkhouser

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age. _____ years
 7. Birth date of deceased (mo., day, yr.) January 7, 1932
 8. AGE: Years 15 Months 5 Days 14 hrs. _____ min.
 9. Birthplace Luke, Allegany, Maryland
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business

FATHER
 12. Name Walter J. Funkhouser
 13. Birthplace Lost City, West Virginia
 MOTHER
 14. Maiden name Martha Whitaker
 15. Birthplace Capon Bridge, West Virginia

16. Informant Walter Funkhouser
 Address 90 Mullen Avenue, Luke, Maryland

17. Burial Date thereof June 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport, Maryland

18. Funeral director Ellsworth S. Roal
 Address Westernport, Maryland

19. June 23 1947 P. E. Berry MD
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947 at 1:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to June 21 1947 and that I last saw him alive on June 21 1947

Immediate cause of death Carcinoma of Cervical spinal cord DURATION 3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of cervical spinal cord Date of op. Apr 1-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. E. Berry MD M. D. or other

Address Piedmont, W. Va. Date signed 6/23/47

RECEIVED

JUN 24 1947

BUREAU V S

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04620 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town (rural) North Branch R.F.D. 4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cumberland (Rural) RFD 4

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town (Rural) Near Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 4 North Branch
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Pearl Elizabeth Galliher

3. (b) Social Security Number

None

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Frank R. Galliher

6. (c) If alive, give age 48 years

7. Birth date of

deceased (mo., day, yr.) Dec. 18 - 1899

8. AGE:

Years

Months

Days

If less than one day

57

6

0

hrs.

min.

9. Birthplace Little Orleans Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name F. William Twigg

13. Birthplace Little Orleans Md.

MOTHER

14. Maiden name Mary Catherine Leighty

15. Birthplace Little Orleans Md.

16. Informant Frank R. Galliher

Address

North Branch RFD # 4

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 21 1947
(month) (day) (year)

Cemetery or crematory Davis Memo. Cem.

Location R.F.D. 4 Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

19

47

Walter H. Smith M.D.
acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw her alive Dead June 18 1947

Immediate cause of death

Chronic Myocarditis

DURATION

several
years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address

Cumberland Md.

Date signed

6-15-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 24 1947

BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

04619

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 yrs
Hospital, institution, or street address where death occurred:
501 2nd Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 2nd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Annie Gatehouse

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elmer Gatehouse

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1870

8. AGE: Years 77 Months 0 Days 23 If less than one day hrs. min

9. Birthplace Frostburg, Allegheny Co, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm Bradley

13. Birthplace Wales

14. Maiden name Margaret Thomas

15. Birthplace Wales

16. Informant Mrs Martha Allison

Address 2315 - 18th St - Akron O.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 3, 1947
(month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Frostburg, Md.

18. Funeral director John J. Hager

Address Cumberland, Md

19. June 3, 1947 (Date rec'd by registrar) J. P. Paulini, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1947 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-31-44 to June 1, 1947

and that I last saw him alive on May 26, 1947

Immediate cause of death Suppurative DURATION

Due to Generalized

Enteritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. F. Williams M. D. or other

Address Cumberland Date signed 6-1-47

MARGIN RESERVED FOR BINDING

I

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten text, possibly a date or reference number, located in the upper left corner.

Handwritten text, possibly a date or reference number, located in the upper right corner.

Large block of handwritten text, possibly a letter or report, spanning the middle of the page.

0581

RECEIVED
JUN 11 1947
U.S. AIR FORCE

Extensive handwritten text, possibly a letter or report, located in the lower half of the page.

The Major

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

570 Cumberland St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 570 Cumberland St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna M. Grabensterin

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Wm H Grabensterin

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1863

8. AGE: Years Months Days If less than one day
84 4 7 hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Frank Doellner13. Birthplace Germany14. Maiden name Elizabeth Handel15. Birthplace Germany16. Informant Mrs. Margaret M. YellonAddress Cumberland Md.

17. Buried Date thereof 6/23/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter & Pauls Cem.Location Loyette St.18. Funeral director Louis Stern Inc.Address Cumberland Md.

19. June 21, 1947 Walter R. Frank, M.D.
 (Date rec'd by registrar) acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947, at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/10/47 to 6/21/47and that I last saw him alive on 6/21/47

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 daysDue to General Arterio SclerosisMitral Heart DiseaseDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) None

Means of injury Injured at work?

23. SIGNATURE J. H. Mattheus MDAddress 6/21/47 101 E. 1st St.Date signed 6/21/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 24 1947

BUREAU OF

04622

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 74 yrs.
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 414 Oldtown Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

George Jos. Green

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Madeline Beneshel

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 2 1873

8. AGE: Years Months Days If less than one day

74 1 28 _____ hrs. _____ min.

9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Retired Tin Plate11. Industry or business worker12. Name George J. Green13. Birthplace Baltimore Ind.14. Maiden name Margaret Cresser15. Birthplace Baltimore Ind.16. Informant F J CreganAddress Cumberland17. Burial Date thereof July 3 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Paul Con.Location Cumberland18. Funeral director Lonis Stern Inc.Address Cumberland Ind.19. July 2 47 Walter R. Touby, M.D.
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 5:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 30 1947and that I last saw him alive on June 30 1947

Immediate cause of death _____ DURATION _____

Chronic DegenerativeDue to neuropathy

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

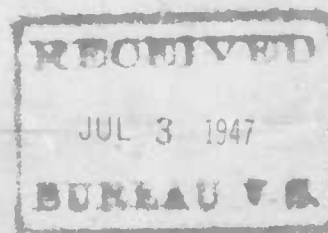
23. SIGNATURE Walter R. Touby, M.D. M. D. or other _____Address 1000 Ave Date signed 7/6/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-6-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04623

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 Years
Hospital, institution, or street address where death occurred:
Rt 2, Cumberland, Md. Baltimore Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 2, Cumberland, Md. Baltimore Pike
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Charles Cross

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Annie Gross

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14 1871

8. AGE: Years 76 Months 4 Days 3 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Consold Gross

13. Birthplace Cumberland, Md.

14. Maiden name Amanda Hendrickson

15. Birthplace Cumberland, Md.

16. Informant Mrs Leslie Wilson

Address Rt 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/47
(month) (day) (year)

Cemetery or crematory Plesant Grove Cemetery

Location Rt 2, Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 20 47 Winters R. Frank, Md.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 47 at 11-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/12 19 46 to 6/17 19 47
and that I last saw him alive on 6/14/47

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John W. Rozman M.D.

Address Cumberland, Md. Date signed 6/18/47

MARGIN RESERVED FOR BINDING

VS A15 9-25-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1947

BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04624

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

213 Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 213 Washington St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Walter Pierce Gross

3. (b) Social Security Number

705-07-6608

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anna Burkhart Gross

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 22, 1883

8. AGE:

Years

Months

Days

If less than one day

631613

hrs.

min.

9. Birthplace

Town Creek, Md.
(Town, county, and state)10. Usual occupation Retired Engineer11. Industry or business B. & O. R.R. Co.

FATHER

12. Name

Frank P. Gross

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Emily Hudson

15. Birthplace

Penna.16. Informant Mrs. Anna GrossAddress 213 Washington St. Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 8, 1947
(month) (day) (year)Cemetery or crematory Trinity Lutheran Cem.Location Cumberland, Md.18. Funeral director Charles L. George

Address

Cumberland, Md.19. June 7, 47
(Date rec'd by registry)J. P. Faulkner, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3, 1947 to June 5, 1947
and that I last saw him alive on June 3, 1947

Immediate cause of death

DURATION

Coronary Thrombosis ?Coronary Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NoneDate of op. None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. F. Williams
Address Cumberland Date signed 6-7-47

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JUN 11 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13102

CERTIFICATE OF DEATH

Dr. Heever 84625

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 Years
 Hospital, institution, or street address where death occurred:
115 Front Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County WALKER
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 Front Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

WILLIAM HENRY HARDEN

3. (b) Social Security Number

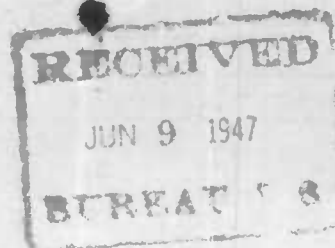
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widower</u>
6. (b) Name of husband or wife <u>Laura Shaffer Harden</u>		
6. (c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) <u>January 14, 1862</u>		
8. AGE: Years <u>85</u>	Months <u>4</u>	Days <u>18</u> hrs. min.
9. Birthplace <u>Keyser, Mineral West Virginia</u> (Town, county, and state)		
10. Usual occupation <u>Railroad Conductor (Retired)</u>		
11. Industry or business <u>Railroad</u>		
12. Name <u>NOT KNOWN</u>		
13. Birthplace		
14. Maiden name <u>NOT KNOWN</u>		
15. Birthplace		

16. Informant <u>Carrie Harden</u>
Address <u>Westernport, Maryland</u>
17. Burial <u>Methodist Cemetery</u> (Burial, cremation, or removal. Which?) Date thereof <u>June 5, 1947</u> (month) (day) (year)
Cemetery or crematory <u>Mt Savare, Maryland</u>
Location <u>Ellsworth S. Boal</u>
18. Funeral director <u>Westernport, Maryland</u>
Address
19. <u>June 5</u> 19 <u>47</u> (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>June 2</u> 19 <u>47</u> at <u>5:30pM</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 1</u> 19 <u>47</u> to <u>June 2</u> 19 <u>47</u> and that I last saw him <u>alive on June 2nd</u>
Immediate cause of death <u>Ch. Cardiac Vascular</u>
Other conditions <u>cardiac disease</u>
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 8 months of death)
Major findings of operations.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE <u>Dr. Heever</u> M. D. or other
Address <u>Westernport, Md</u> Date signed <u>6/3/47</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04626

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since March 9-1947

Hospital, institution, or street address where death occurred

since March 9-1947 Rear 224 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. rear) 224 N. Mechanic St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Gary Hess

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 9 1947

8. AGE:

Years

Months

Days

If less than one day

0321

hrs.

min.

9. Birthplace

Cumberland Allegany Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name Francis Hess13. Birthplace Cumberland, Md.

MOTHER

14. Maiden name Edwina Gibson15. Birthplace Terra Alta W.Va.

16. Informant

Francis R. HessAddress 224 N. Mechanic St. Cumberland Md

17.

Burial Date thereof July 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland Md.

18. Funeral director

John J. Hofer

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

19

47Walter P. Frank, M.D.
Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47, at 6 A. M. about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him in Dead June 30 19 47

Immediate cause of death

Bronchopneumonia

DURATION

about 2days

Due to

Due to

Other conditions 7 Months Premature

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. therAddress Cumberland, Md. Date signed 6-30-1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1947

BUREAU V A

Within corporate limits
DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

04627

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 19 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... PENNSYLVANIA County... BEDFORD
City or town... EVERETT
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O. BOX 118
(If rural, give LOCATION)
2(a) If veteran, name war... ☒

3. (a) FULL NAME
ROBERT H. HEWETT

3. (b) Social Security Number
181-10-0298

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife DOROTHY WHETSTONE
6. (c) If alive, give age 25 years
7. Birth date of deceased (mo., day, yr.) NOVEMBER 26, 1916
8. AGE: Years 30 Months 6 Days 27 If less than one day
hrs. min.

9. Birthplace... PENNSYLVANIA
(Town, county, and state)
10. Usual occupation... INSURANCE AGENT
11. Industry or business
12. Name... JOHN HEWETT
13. Birthplace... ENGLAND
14. Maiden name... LOUIE JONES
15. Birthplace... ENGLAND

16. Informant... MEMORIAL HOSPITAL
Address... CUMBERLAND, MARYLAND
17. Removal Date thereof... 4/13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory... Everett Cem
Location... Everett, Penna.
18. Funeral director... R. E. Hupp
Address... Saxton Penna
19. June 13, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... JUNE 13, 1947 at 5:25 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 25, 1947 to June 13, 1947
and that I last saw him alive on June 13, 1947
Immediate cause of death... Acute Myocardial Infarction DURATION 1 day
Due to... Hypertension, Coroner 3 yrs?
Due to... Myocardial Infarction
Other conditions... Myocardial Infarction
(Include pregnancy within 3 months of death)
Major findings of operations... Coronary Artery Disease
Date of op. ?
Autopsy results... None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE... Samuel Jacobson M. D. or other
Address... 1414 N. Charles St. Baltimore Date signed... 6/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04628

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred:
315 South St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 315 South St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Madeline Virginia Hoyle

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife John W. Hoyle
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept 20 1853
8. AGE: Years 93 Months 9 Days 6 If less than one day _____ hrs. _____ min.
9. Birthplace Morgan Co. W. Va.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business at Home
FATHER 12. Name Harrison Miller
13. Birthplace W. Va.
MOTHER 14. Maiden name Hanson
15. Birthplace W. Va.

16. Informant J. Staten Hoyle
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 29 47
(month) (day) (year)
Cemetery or crematory Stottlers Cem.
Location Cross Rds. W. Va.
18. Funeral director Louis Stein Inc.
Address Cumberland

19. 6-28 19 47 White & County, Md.
(Date rec'd by registrar) acting registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 47 at 11 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 47 to June 26 19 47
and that I last saw him alive on June 26 19 47
Immediate cause of death arteriosclerosis
debility of age
Due to 59
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury Injured at work?

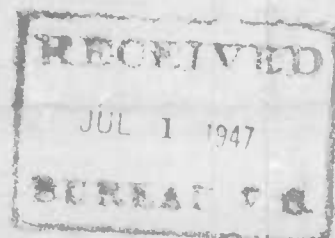
23. SIGNATURE W. E. B. Owens M. D. or other
Address 133 Va. Ave. Date signed 6/27/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04629

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 15 hours
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? about 15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
City or town Near) Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.1 Homewood Addition
(If rural, give LOCATION)
2. (a) If veteran, name war 1st World War. ☒

3. (a) FULL NAME

James Herbert Jewell

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Susie Plummer Jewell
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 26- 1920

8. AGE: Years 27 Months — Days 19 It less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Laborer, County roads.

11. Industry or business

FATHER 12. Name Charles E. Jewell
13. Birthplace Rockingham Co. Va.

MOTHER 14. Maiden name Sarah May Cline
15. Birthplace Rockingham Co. Va.

16. Informant Charles E. Jewell
Address Route 1, Cumberland Md.

17. Buried Date thereof June 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ross Hill Cemetery
Location Cumberland Md.

18. Funeral director Louis Stein Inc.
Address Cumberland Md.

19. June 17, 1947 Winters R. French M.D.
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947 at 5.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____
and that I last saw him alive on June 15, 1947

Immediate cause of death Basil fracture of skull, severe concussion of brain & fractures of facial bones about 15 hrs.

Due to Automobile hit large rock side of road.

Due to _____
Other conditions Multiple lacerations of face, forehead, scalp & neck
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Auto Accident Date of 6-15-1947
Where did injury occur? Barrelsville Allegany Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Jct. Mt Savage & Wellersburg Rd.
Means of injury Auto hit rock Injured at work? no

Deputy Medical Examiner Allegany Co.
23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or other _____
Address Cumberland, Md. Date signed 6/15/47

MARGIN RESERVED FOR BINDING

9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04630

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Allegheny County Infirmary
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 623 Columbia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella "Kahl" Kiiffner
3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George Kiiffner

7. Birth date of deceased (mo., day, yr.) May 20, 1876

8. AGE: Years 71 Months 1 Days 1 If less than one day
hrs. min.

9. Birthplace Accident, Garrett, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name William H. Kahl

13. Birthplace Germany

14. Maiden name Louise Spaerlsin

15. Birthplace Maryland

16. Informant Mrs. Margaret Yutz

Address 208 Independence St.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 23, 1947
(month) (day) (year)

Cemetery or crematory Trinity Lutheran Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. June 23, 1947 (Date rec'd by registrar) Winter R. Bank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1947 and that I last saw him alive on June 20, 1947

Immediate cause of death Myocardial Failure

Due to Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other
Address 110 S. Centre St. Date signed 6-21-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

June

RECEIVED
JUL 1 1947
BUREAU F. B.

DR. MEYERS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

04631
Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 DAYS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....2 MAPLE ST.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

FLOYD E. KINES

3. (b) Social Security Number

None

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....SINGLE
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) June 13, 1931 6.(c) If alive, give age..... years
 8. AGE: Years.....15 Months.....11 Days.....20 If less than one day..... hrs. min.

9. Birthplace.....CUMBERLAND, ALLEGANY, MARYLAND
(Town, county, and state)10. Usual occupation.....STUDENT

11. Industry or business.....

FATHER 12. Name.....MACKLYN KINES
 13. Birthplace.....Maryland

MOTHER 14. Maiden name.....CATHERINE WEIMER
 15. Birthplace.....PENNSYLVANIA

16. Informant.....Mrs. Catherine Longerbeam
 Address.....104 Gleason St. Cumberland, Md.

17. Burial.....June 6, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....Cooks Mills Cem.
 Location.....Cooks Mills, Penna.

18. Funeral director.....Charles L. George
 Address.....Cumberland, Md.

19. June 6, 19 47 J. P. Frankhi, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 3, 19 47 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 10, 1947 19 47 to June 3, 19 47
 and that I last saw him alive on 6/3/47

Immediate cause of death.....central cranial hemorrhage
 Due to.....Thrombocytopenic Purpura
 Due to.....old father
Idiopathic

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....[Signature] M. D. or other
 Address.....Cumberland Md. Date signed.....6/5/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU 76

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 51 yrs

Hospital, institution, or street address where death occurred:

Allegany Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 635 Columbia Ave.
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

Collins "C" Lease

3. (b) Social Security Number

217-10-1656

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed6. (b) Name of husband or wife Bessie Butler

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) June 14, 18868. AGE: Years Months Days If less than one day
50 11 21 hrs. min.9. Birthplace Cumberland, Allegany Co. Md.
(Town, county, and State)10. Usual occupation Bortinder11. Industry or business Cresaptown Vol. Fire Co.12. Name Frank Lease13. Birthplace West Va.14. Maiden name Margaret Huff15. Birthplace West Va.16. Informant George Lease
Address 447 Henderson Ave. Cumberland, Md17. Burial Date thereof June 8, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Biertown CemeteryLocation Randolph, Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md19. June 7, 1947 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31, 1947 to June 5, 1947
and that I last saw him alive on June 5, 1947Immediate cause of death Cerebral Arteriosclerosis DURATION 5 daysCerebral Degeneration 5 days
Hypertension 5 days
Kopchakoff's PsychosisDue to HypertensionDue to Generalized ArteriosclerosisDue to Alcoholism, chronicOther conditions Coronary heart disease 1 1/2 years

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hewersman M. D. or otherAddress Cresaptown, W. Va. Date signed June 6, 1947

RECEIVED

JUN 11 1947

STREAN 68

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 128

CERTIFICATE OF DEATH

Reg. Dist. No. 9

04633

1. PLACE OF DEATH: Allegany
County Frostburg
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred Miners Hospital
How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town 58 Terrace Ave
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas Franklin Lewis

3. (b) Social Security Number 214-01-6654

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Mae Lewis
7. Birth date of deceased (mo., day, yr.) June 27, 1888
6.(c) If alive, give age 52 years
8. AGE: Years 58 Months 11 Days 12 If less than one day hrs. min.

9. Birthplace Frostburg Allegany Md.
(Town, county, and state)
10. Usual occupation Miner engineer
11. Industry or business
12. Name John T. Lewis
13. Birthplace Maryland
14. Maiden name Margaret Thomas
15. Birthplace Maryland

16. Informant Thos. Lewis Jr
Address Frostburg Md.
17. Burial Date thereof June 11, 1947
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg Md.
18. Funeral director J. R. Overst
Address Frostburg Md.

19. 6-11 19 47 Wm. Harvey N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 47 at 12:20 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 19 47 to June 9 19 47
and that I last saw him alive on June 8 19 47
Immediate cause of death acute cardiac dilatation DURATION sudden
Due to myocardial infarction 1 day
Due to post-operative cardiac
Other conditions due to operations 1945
following cholecystectomy
(Include pregnancy within 3 months of death)

Major findings of operations (Date of op.)
Autopsy results (Date of op.)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide (Date of)
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury (Injured at work?)
23. SIGNATURE Wm. Harvey N. Roe M. D. or other
Address Frostburg Md. Date signed 6-9-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15714

RECEIVED

JUN 13 1947

BUREAU V 8

Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

04634

MD. No. 6 110 JUN 23 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Borden Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Lealand Francis Leavelle

3. (b) Social Security Number

705-07-6705

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Eva Smith
6. (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) Nov. 10th., 1900
8. AGE: Years 46 Months 7 Days 7 If less than one day
hrs. min.

9. Birthplace Pinto, Allegheny, Ind.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Self-employed

12. Name Elmer W. Leavelle

13. Birthplace Allegheny, Ind.

14. Maiden name Eva Leavelle

15. Birthplace Allegheny, Ind.

16. Informant Dr. Robert Leavelle

Address 10 Central St. Frostburg

17. Burial Date thereof 6-19-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bier Cemetery

Location Frostburg, Ind.

18. Funeral director Joseph Wagner

Address Frostburg, Ind.

19. 6-18 19 47 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 47 at 9:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 16 19 47 to June 17 19 47
and that I last saw him alive on June 17 19 47

Immediate cause of death Heart disease with failure
DURATION 2 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE Hilda Janselwalter, M.D.
M. D. or other

Address Frostburg, Ind. Date signed 6/17/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49a

CERTIFICATE OF DEATH

04635

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 years
 Hospital, institution, or street address where death occurred:
231 Columbia St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Independence St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Matilda Lookenott

3. (b) Social Security Number

214-05-7149

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Thomas Lookenott
 6. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) May 20 1890
 8. AGE: Years 57 Months 0 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Allegany Co., Maryland
 (Town, county, and state)

10. Usual occupation Sales Lady

11. Industry or business Martins Dress Shop

12. Name Nicholas Scheermesser

13. Birthplace Cumberland, Md.

14. Maiden name Anna Elizabeth Herpick

15. Birthplace Cumberland, Md.

16. Informant Walter E. Scheermesser

Address 231 Columbia St, Cumberland, Md.

17. Burial Date thereof 6/21/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Luke's Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 21 19 47 Walter R. Frantz, M.D.
 (Date rec'd by registrar) acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 47 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 41 to June 19 19 47
 and that I last saw him alive on June 19 19 47

Immediate cause of death Carcinoma of the DURATION

Cervix

Due to Obesity

Due to Obesity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter R. Frantz, M.D. M. D. or other

Address Cumberland Date signed 6/21/47

RECEIVED

JUN 24 1947

ST. HEAT

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04636

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
130 Bedford Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 130 Bedford St.
(If rural, give LOCATION)
2(a) If veteran, name war

3(a) FULL NAME Mrs. Rose Adelaide Malcolm
3(b) Social Security Number None

4. Sex Female
5. Color or race White
6(a) Single, married, widowed, or divorced Married

6(b) Name of husband or wife Archibald Malcolm

7. Birth date of deceased (mo., day, yr.) July 10 1872

8. AGE: Years 74 Months 11 Days 20 If less than one day hrs. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name John L. Leatherman

13. Birthplace Pennsylvania

14. Maiden name Adela Weatherell

15. Birthplace Pennsylvania

16. Informant John Malcolm

Address 130 Bedford St., Cumberland, Md.

17. Burial Date thereof July 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. July 2 1947 Winters R. Stewart M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive Dead June 30 1947

Immediate cause of death Chronic Myocarditis

DURATION several years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

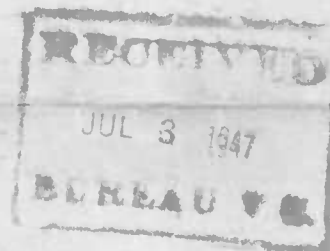
Deputy Medical Examiner - Allegany

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other
Address Cumberland, Md. Date signed 6-30-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town RURAL Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 yrs
Hospital, institution, or street address where death occurred:
Spring Gap, Route 4, Cumberland Md.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Rural Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 4, Spring Gap
(If rural, give LOCATION)
2.(a) If veteran, name war. —

3. (a) FULL NAME

Kate Alice Mc Cabe

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James P. McCabe

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 2, 1878

8. AGE: Years 68 Months 6 Days 1 If less than one day — hrs. — min.

9. Birthplace Spring Gap, Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business —

12. Name Wm. B. Wheeler

13. Birthplace Bridgport, Ohio

14. Maiden name Paulah Davis

15. Birthplace Spring Gap, Md.

16. Informant John D. Wheeler

Address Spring Gap, Allegheny Co., Md.

17. Burial Date thereof June 5, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Cumberland Md

18. Funeral director Louis Stoner, Inc.

Address Cumberland Md

19. June 5, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 3, 1947 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1936 to June 3, 1947

and that I last saw him/her Sept. 2, 1947 alive on Sept. 2, 1947

Immediate cause of death Cerebral vascular accident

Due to General arteriosclerosis

7 hypertension

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other —

Address 110 S. Centre St. Date signed 6-4-47

MARGIN RESERVED FOR BINDING

VS A15 946.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 Union St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lavitta Jean McCleaf

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

June 8, 1947

8. AGE:

Years

Months

Days

If less than one day

0010

hrs.

min.

9. Birthplace

Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Donald T. McCleaf

13. Birthplace

Gettysburg, Pa.

MOTHER

14. Maiden name

Bertha G. Johnson

15. Birthplace

Cumberland, Md

16. Informant

Donald R. McCleaf

Address

220 Union St. Cumberland, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

June 19, 1947
(month) (day) (year)

Cemetery or crematory

Zion Memorial Park

Location

Near Cumberland, Md

18. Funeral director

John J. Haley

Address

Cumberland, Md

19.

(Date rec'd by registrar)

June 19, 1947
W. R. Trautz, Md
acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1947 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8, 1947, to June 18, 1947
and that I last saw him alive on June 18, 1947

Immediate cause of death

Fetal asphyxiation

DURATION

Due to

Too Prematurely

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Julius B. Hartman
M. D. or otherAddress 112 Bedford St. Date signed 19 June 1947

RECEIVED

JUN 24 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

04639

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Reardon Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Elsie McGreevy

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John J. McGreevy

7. Birth date of

deceased (mo., day, yr.)

Feb. 12

6. (c) If alive, give age..... years

89

8. AGE:

Years

Months

Days

If less than one day

5141

hrs.

min.

9. Birthplace Piedmont W. Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name John Legge13. Birthplace Piedmont W. Va.

MOTHER

14. Maiden name Nannie Beall15. Birthplace Piedmont W. Va.16. Informant John McGreevyAddress Westernport, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 16-47

(month) (day) (year)

Cemetery or crematory PhelpsLocation Westernport, Md.18. Funeral director W. H. and Fred SchAddress Piedmont W. Va.19. June 16

(Date rec'd by registrar)

19 47Registrar W. H. and Fred Sch

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 47 at 10.30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him/her alive Dead June 13 19 47

Immediate cause of death

Acute Dilatation of the heart

DURATION

atonceDue to Over exertionhohing in the garden

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co23. SIGNATURE H. V. Deming M.D. M. D. or otherAddress Cumberland Md Date signed 6/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 11 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)Street No. 315 MARYLAND AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

McMILLEN, WILLIAM GARY

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

August 29, 1946

8. AGE:

10X

Years

Months

Days

If less than one day

26

hrs.

min.

9. Birthplace Cumberland, Alleg. Co., Md.
(Town, county, and state)10. Usual occupation INFANT

11. Industry or business

12. Name McMILLEN, CARL13. Birthplace MD., Midland14. Maiden name TASCHENBURGER, GENEVIEVE15. Birthplace MD., Spring Gap16. Informant MEMORIAL HOSPITALAddress Cumberland, Md.17. Burial Date thereof June 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shiloh CemLocation Westernport, Md.18. Funeral director Ellsworth & BondAddress Westernport, Md.19. June 27, 47 Westernport, Md.
(Date rec'd by registrar) (City or town) (County) (State)

DR. ELIASON

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 25, 1947 at 11:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24, 1947 to June 25, 1947
and that I last saw him alive on June 25, 1947

Immediate cause of death

Mediastinal Emphysema
Mediastinal Emphysema

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

V. U. Season
26 Green St. Cumberland, Md.
Address Date signed 6/25/47

RECEIVED

JUL 1 1947

BLANK 6

Outside of
City Limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

93d

04641
4

Reg. Dist. No.

1. PLACE OF DEATH:
County Allegheny
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Rt. 2, ~~Cumberland, Md~~ Creek Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 2, Creek Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Lillie Cheston "Johnson" Metzner

3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife George J. Metzner
6. (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) October 28, 1871

8. AGE: Years 75 Months 8 Days 1 If less than one day hrs. min.

9. Birthplace Cumberland, Allegheny Co., Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Cheston Johnson
13. Birthplace ?

MOTHER 14. Maiden name Louise Jackson
15. Birthplace ?

16. Informant George J. Metzner
Address Rt. 2, Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 1, 1947
(month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director John J. Hefner
Address Cumberland, Md.

19. Date rec'd by registrar July 1, 1947 Walter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947 at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1947 to June 29, 1947
and that I last saw her alive on June 29, 1947

Immediate cause of death Myocarditis
Arteriosclerosis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 8 months of death)

DURATION
<u>3 yrs</u>
<u>5 yrs</u>

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clayton Jones M. D. or other
Address Cumberland Date signed 6/30/47

RECEIVED

JUL 3 1947

BUREAU 7 C.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04642
4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

Allegheny County InfirmaryHow long in hospital or institution? 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 30 Laing Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Christopher Miller

3. (b) Social Security Number

705-09-6100

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elizabeth Miller6. (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) March 11, 18818. AGE: Years 66 Months 3 Days 15 If less than one day
..... hrs. min.9. Birthplace Somerset Co., Pa.
(Town, county, and state)10. Usual occupation Freight conductor11. Industry or business B & O T. P.12. Name Franklin Miller13. Birthplace Bedford Co., Pa.14. Maiden name Anna Bowers15. Birthplace Cumberland, Md.16. Informant Mrs. Elizabeth MillerAddress Cumberland, Md.17. Burial Date thereof June 28, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HagerAddress Cumberland, Md.19. June 28, 1947 Winters R. Trout, M.D.
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 to June 26, 1947and that I last saw him alive on June 24, 1947

Immediate cause of death

Acute myocardial failure DURATION 5 minDue to arterio-sclerotic hypertensioncardiovascular disease 10 yrs

Due to

Other conditions

.....

.....

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

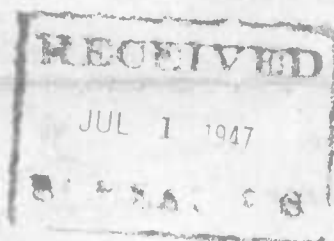
23. SIGNATURE Arthur F. Jones M.D.
M. D. or otherAddress 110 S. Centre St. Date signed 6-27-47

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Arthur Jones



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04643

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 47 years
 Hospital, institution, or street address where death occurred:
453 Baltimore Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 453 Baltimore Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jacob Ambrose Miller

3. (b) Social Security Number

705-05-8054

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edith Roberts Miller

7. Birth date of

deceased (mo., day, yr.)

July 27, 1884

8. AGE:

Years

Months

Days

If less than one day

621028

hrs.

min.

9. Birthplace

Weaverton, Washington, Maryland
(Town, county, and state)

10. Usual occupation

Chief train dispatcher

11. Industry or business

B & O RR

FATHER

12. Name

Preston E. Miller

13. Birthplace

Weaverton, Md

MOTHER

14. Maiden name

Mary E. Briggs

15. Birthplace

Ogdonsburg, N.Y.

16. Informant

Mrs. Edith Miller

Address

453 Baltimore Ave., Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 27, 1947
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hoffer

Address

Cumberland, Md.

19. Date rec'd by registrar

June 27, 1947Walter J. Frank, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1947 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1946 to June 25, 1947
and that I last saw him alive on June 23rd, 1947

Immediate cause of death

DURATION

MI Hemiplegia1 year

Due to

arterial hypertensionand 22 days.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. M. Traskis, Jr. M.D.

Address

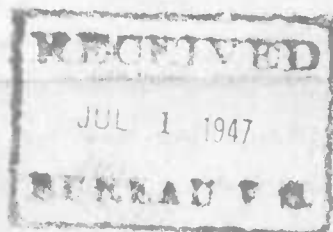
Cumberland Md

M. D. or other

Date signed

6/26/47

1134



DR. W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

04644

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs 3 mos 23 days

Hospital, institution, or street address where death occurred:

MEMORIAL Hospital

How long in hospital or institution? 51 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND..... County.....ALLEGANY

City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 ELM STREET

(If rural, give LOCATION)

2.(a) If veteran, name war I World War.

3. (a) FULL NAME

JOHN MILLER
John I. Miller

3. (b) Social Security Number

714-05-4875

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife MARY C. COOK

7. Birth date of

deceased (mo., day, yr)

February 26 1895

6.(c) If alive, give age 47 years

8. AGE:

Years

Months

Days

If less than one day

52

3

23

hrs.

min.

9. Birthplace.....MARYLAND

(Town, county, and state)

10. Usual occupation.....Salesman

11. Industry or business

FATHER

12. Name.....JOHN MILLER

13. Birthplace.....MARYLAND

MOTHER

14. Maiden name.....WAGNER, ANNA

15. Birthplace.....MARYLAND

16. Informant.....Mrs Mary Cook Miller

Address

Cumberland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof

June 21 47

Cemetery or crematory

St Peter & Pauls Cem.

Location

Cumberland

18. Funeral director.....Louis Stein Inc

Address

Cumberland

19. June 20 19 47

White, R. Trautz, Jr.
acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....JUNE 19th.....19 47.....at 10:07A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-24-47 to 6-19-47

and that I last saw him alive on 6-19-47

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

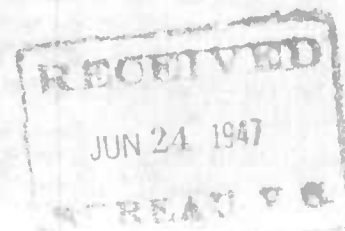
Cumberland 6-19-47

MARGIN RESERVED FOR BINDING

VS A75 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

CB

04645

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Day
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State West Virginia County Hampshire
City or town Springfield
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2.(a) If veteran, name war _____

3.(a) FULL NAME Thurman O Moreland
3.(b) Social Security Number 705-09-4870

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna Belle Moreland

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) November 1 1888

8. AGE: Years 58 Months 7 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Springfield, Hampshire Co., West Va.
(Town, county, and state)

10. Usual occupation Trackman

11. Industry or business Baltimore & Ohio Railroad

12. Name George Moreland

13. Birthplace Springfield, W. Va.

14. Maiden name Cora Starnes

15. Birthplace Springfield, W. Va.

16. Informant Mrs Dorothy Hannas

Address Romney, W. Va.

17. Burial (Burial, cremation, or removal. Which?) 6/29/47
(month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Springfield, W. Va.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. June 28, 1947 (Date rec'd by registrar) White R. Frantz, Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 26 1947 and that I last saw him alive on June 25 1947

Immediate cause of death acute coronary occlusion

Due to chronic myocarditis

Due to atherosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

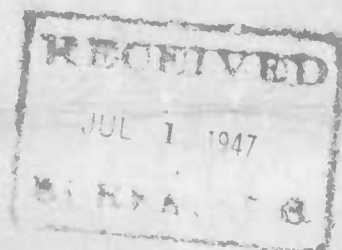
23. SIGNATURE Wings M.D. M.D. or other

Address 59 Green St. Date signed 6-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04646

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 minutes
Hospital, institution, or street address where death occurred:
Allegheny Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. #6, McMullen, Newby
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Marilyn Neal

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) June 1, 1947 @ 2.55 P.M. 6.(c) If alive, give age years
8. AGE: Years Months Days If less than one day hrs. 35 min.

9. Birthplace Cumberland, Alleg. Co., Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Joseph Clyde Neal
13. Birthplace Columbus, Ohio
14. Maiden name Wilma Anita Blanch
15. Birthplace Johnstown, Pennsylvania

16. Informant

Mrs. Wilma Neal
Address Rd. #6, McMullen, Newby, City
17. Burial Date thereof June 3, 1947
(Burial, cremation, or removal) Which? (month) (day) (year)
Cemetery or crematory Lyons Cemetery
Location Lyons, Md.

19. Funeral director

Louis Stein, Inc.
Address Cumberland, Md.
19. June 2 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 47 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 47 to June 1 19 47
and that I last saw him alive on June 1 19 47

Immediate cause of death premature baby
DURATION 5 1/2 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Stein M.D.

Address 59 Chene St. Date signed 6-1-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Minutes
 Hospital, institution, or street address where death occurred:
In route to Memorial Hospital
 How long in hospital or institution? Dead when admitted.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Va. County Mineral
 City or town Ridgely
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 35 Knobley
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Charles Berry Pittman

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 17- 1947 6. (c) If alive, give age _____ years

8. AGE: Years 0 Months 3 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Allegany Md.
 (Town, county, and State)

10. Usual occupation

11. Industry or business

12. Name Alvin W. Pittman
 13. Birthplace Parson W.Va

14. Maiden name Martha Hershberger
 15. Birthplace Ridgely W.Va.

16. Informant Alvin W. Pittman
 Address Ridgely W.Va.

17. Burial Date thereof July 1, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory City Cemetery
 Location Parsons, W. Va.

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. July 1, 19 47 Walter R. Frantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47 at 5:30 A.M. about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him Dead June 30 19 47

Immediate cause of death bronchopneumonia & tracheo bronchitis DURATION about 2 days

Due to

Due to

Other conditions one of 7 mo. premature twins
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
 M. D. or other

Address Cumberland Md. Date signed 6-30-1947

RECEIVED

JUL 3 1947

BUREAU OF

Reg. Dist. No. 0

MARGIN RESERVED FOR BINDING

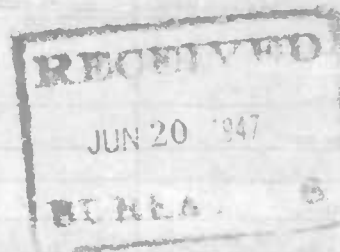
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... <u>Allegany</u>		(For newborn infants give residence of mother)	
City or town..... <u>Concordia</u>		State..... <u>Maryland</u> County..... <u>Allegany</u>	
(If outside city or town limits, write RURAL and give nearest town)		City or town..... <u>Concordia</u>	
How long in above place of death?..... <u>74 years</u>		(If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred: <u>Hancock Street</u>		Street No..... <u>Hancock Street</u>	
How long in hospital or institution?..... <u>1</u>		(If rural, give LOCATION)	
3. (a) FULL NAME <u>Anna Elizabeth Pearson Reiber</u>		2. (a) If veteran, name war..... <u>1</u>	
3. (b) Social Security Number <u>1</u>			
4. Sex..... <u>Female</u> 5. Color or race..... <u>White</u> 6. (a) Single, married, widowed, or divorced..... <u>Widowed</u>			
6. (b) Name of husband or wife..... <u>Mr. H. Reiber</u>			
7. Birth date of deceased (mo., day, yr.)..... <u>Sept 2, 1872</u> 6. (c) If alive, give age..... <u>1</u> years			
8. AGE: Years..... <u>74</u> Months..... <u>9</u> Days..... <u>7</u> If less than one day..... hrs. min.			
9. Birthplace..... <u>Concordia, Allegany Co., Md.</u> (Town, county, and state)			
10. Usual occupation..... <u>Housewife</u>			
11. Industry or business..... <u>Own home</u>			
12. Name..... <u>Benjamin Pearson</u>			
13. Birthplace..... <u>Unknown</u>			
14. Maiden name..... <u>Mary Myers</u>			
15. Birthplace..... <u>Unknown</u>			
16. Informant..... <u>Mrs. Mary Bevan</u>			
Address..... <u>Concordia, Md.</u>			
17. <u>Funeral</u> Date thereof..... <u>June 13, 1947</u> (Burial, cremation, or removal. Which?) (month) (day) (year)			
Cemetery or crematory..... <u>Oak Hill Cemetery</u>			
Location..... <u>Concordia, Md.</u>			
18. Funeral director..... <u>W. E. L. L. L.</u>			
Address..... <u>Concordia, Md.</u>			
19. <u>June 13</u> 19 <u>47</u> <u>Jannet B. Boal</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION			
20. DATE OF DEATH..... <u>June 9, 1947</u> at..... <u>8:30 P.M.</u>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... <u>June 7, 1947</u> to..... <u>June 9, 1947</u>			
and that I last saw him alive on..... <u>June 7, 1947</u>			
Immediate cause of death..... <u>Coronary Occlusion</u>			
Due to.....			
Due to.....			
Other conditions.....			
(Include pregnancy within 3 months of death)			
Major findings of operations.....			
Date of op.....			
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide..... Date of.....			
Where did injury occur?..... (City or town)..... (County)..... (State).....			
Injured at home, farm, industry, public place (where?).....			
Means of injury..... Injured at work?			
23. SIGNATURE..... <u>H. H. H. H.</u> M. D. or other.....			
Address..... <u>Concordia, Md.</u> Date signed..... <u>June 13, 1947</u>			

STANDARD TELEPHONE EXCHANGE

STANDARD TELEPHONE EXCHANGE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

04649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANYCity or town..... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... ALLEGANYCity or town..... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No. #225 INDEPENDENCE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

RICE, GENEVIEVE MRS.4. Sex..... FEMALE Color or race..... Colored

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife..... ROBERT RICE6.(c) If alive, give age..... 40 years7. Birth date of deceased (mo., day, yr.)..... APRIL 18, 19078. AGE: Years..... 40 Months..... 2 Days..... 5 hrs. min.9. Birthplace..... MD.
(Town, county, and state)10. Usual occupation..... DOMESTIC

11. Industry or business.....

12. Name..... XXXXX DAVIS, JAMES13. Birthplace..... MD.14. Maiden name..... BANKS, BESSIE15. Birthplace..... MD.16. Informant..... MEMORIAL HOSPITALAddress..... CUMBERLAND, MD.17. Burial Date thereof..... June 25, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Rose Hill CemeteryLocation..... Cumberland, Md.18. Funeral director..... John P. HodgesAddress..... Cumberland, Md.19. June 25, 1947 Walter R. Lantz, M.D.
Date recorded by registrar..... acting RegistrarDR. HODGES

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH..... JUNE 23, 1947 19..... at 12:35 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 to June 23 1947
and that I last saw him/her alive on June 23 1947Immediate cause of death..... Probable malignancy
or variant DURATION..... 1 yr

Due to.....

Due to..... Lung metastasis ?

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Report incomplete

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. R. Hodges, MD.
M.D. or other

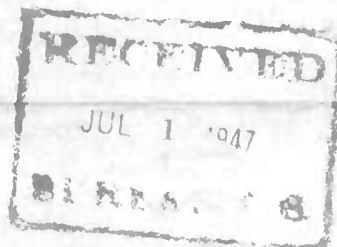
Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL Hospital
How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 448 WILLIAMS STREET,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
WALTER B. RITCHIE

3. (b) Social Security Number
705-05-8152

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
6.(b) Name of husband or wife LUCRETIA RITCHIE
7. Birth date of deceased (mo., day, yr.) 9/3/80 6.(c) If alive, give age 65 years
8. AGE: Years 66 Months 9 Days 23 If less than one day hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual occupation Retired railway clerk
11. Industry or business B. & O. Railway
12. Name GEORGE RITCHIE
13. Birthplace MDARYLAND
14. Maiden name GEORGIANNA JAMES
15. Birthplace MARYLAND

16. Informant Mrs. Lucretia Ritchie
Address 448 Williams St., Cumberland, Md.
17. Burial Date thereof June 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Cem.
Location Cumberland, Md.
18. Funeral director H. Wayne George
Address Cumberland, Md.

19. June 28, 47 Walter B. Ritchie
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 26, 1947 at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1947 to June 26, 1947
and that I last saw him alive on June 21, 1947
Immediate cause of death Coronary Thrombosis
constrictive
Heart Block
Due to Arteriosclerosis
Other conditions
(Include pregnancy within 3 months of death)

DURATION

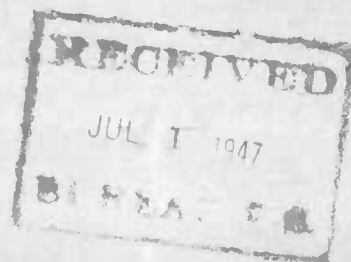
6 days
3 yrs.
5 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Walter B. Ritchie
M. D. or other
Address Cumberland Date signed 6/28/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04651

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Butterfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days (2) 55 yrs
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 days (?)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Rural Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. La Vale
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Ola M. Rooney

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Ernest H. Rooney
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 18, 1892

8. AGE: Years 55 Months 2 Days 21 hrs. min.

9. Birthplace Cumberland, Allegheny Co. Md.
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name James E. Malinphy

13. Birthplace Ireland

14. Maiden name Bridget Twyler

15. Birthplace Ireland

16. Informant Jane M. Bunka

Address La Vale, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof June 11, 1947
 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland Maryland

19. June 11, 47 J. P. Traubler, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 47 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 to June 9 19 47
 and that I last saw him alive on June 8 19 47

Immediate cause of death ruptured heart
failure

Due to malignant hypertension
duration 1 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliabek B. Jones, M.D.
 M.D. of other

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1947
BUREAU OF

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 186a
CERTIFICATE OF DEATH

04652
Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
29 Maple St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 Maple St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Elizabeth Rudy 3. (b) Social Security Number None

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Divorced
6.(b) Name of husband or wife Blas P Rudy
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1861
8. AGE: Years 86 Months 0 Days 24 If less than one day hrs. min.

9. Birthplace Paw-Paw, Morgan Co. W. Va.
(Town, county, and state)

10. Usual occupation House Work

11. Industry or business At Home

12. Name Isaac Hutchinson
13. Birthplace Va

14. Maiden name Margaret Van Cisdale
15. Birthplace Morgan Co - W. Va.

16. Informant James C. Rudy
Address 405 Circle Ave - Jacobsville

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 14, 1947
(month) (day) (year)
Cemetery or crematory Emm Baptist Church Cem.
Location Sargent W. Va.

18. Funeral director John J. Hofer
Address Cumberland Md.

19. June 14, 1947 J.P. Tanker, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947 at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/3 to 6/11 and that I last saw her alive on 6/3

Immediate cause of death uremia DURATION 2 wks

Due to Renal arteriosclerosis (Senility) ? years

Due to
Other conditions Confusions of back & left hip.
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of 2 wks before death

Where did injury occur? (City or town) (County) (State)

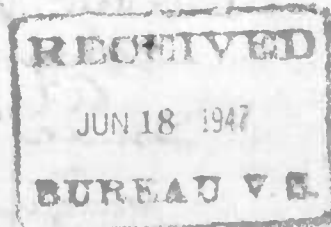
Injured at home, farm, industry, public place (where?) Home
Means of injury Fell from bed to floor (If at work, state) Injured at work?

23. SIGNATURE A. Mission M.D. or other

Address 115 St Centre St Date signed 6/13/47
Cumberland

Dr. Mirkin

Please sign
and call 65-
when ready -



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04653

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Sylvan RetreatHow long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 Browning St.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Mary St Clair

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Arthur St Clair

7. Birth date of deceased (mo., day, yr.)

July 11, 1865

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

811116

hrs.

min.

9. Birthplace Oslo, Norway
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Peter Christopher sen13. Birthplace Norway14. Maiden name ?15. Birthplace Norway16. Informant Mrs. Laura RobertsonAddress 38 Browning St., Cumberland, Md17. Burial Date thereof June 27, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Camp Hill CemeteryLocation Paw Paw, W. Va.18. Funeral director John J. HofferAddress Cumberland, Md.19. June 28 1947 White R. Troutman
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 to June 27 1947and that I last saw her June 27 1947

Immediate cause of death

Acute myocardial failure
Due to Chronic myocarditis

DURATION

5 min15 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

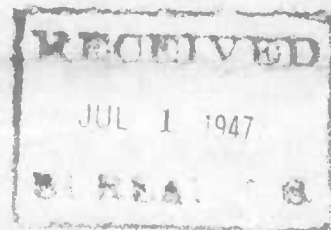
Address 110 S. Centre St. Date signed 6-27-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 04654

1. PLACE OF DEATH:

County Allegheny
 City or town Lancaster, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1-2 weeks
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1-2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State West Virginia County Tucker
 City or town HOAVIS
 (If outside city or town limits, write RURAL and give nearest town)

Street No. L
 (If rural, give LOCATION)

2.(a) If veteran, name war L

3. (a) FULL NAME

Nettie Salada

3. (b) Social Security Number

L

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife Charles W. Salada6.(c) If alive, give age L years7. Birth date of deceased (mo., day, yr.) July 8, 18868. AGE: Years 60 Months 10 Days 28 hrs. L min.9. Birthplace Cherryville, Bedford, Pa
(Town, county, and state)10. Usual occupation House work11. Industry or business Home12. Name Amos Lines13. Birthplace Unknown14. Maiden name " "15. Birthplace " "16. Informant Harry SaladaAddress Lancaster, Md17. Burial Date thereof June 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Davis CemeteryLocation Davis West Virginia18. Funeral director M. EichhornAddress Lancaster, Md19. June 6 1947 Janet M. Bost
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1947, to June 6 1947
 and that I last saw him alive on June 6 1947

Immediate cause of death Carcinoma of stomach
L

DURATION

Due to LDue to LOther conditions L

(Include pregnancy within 3 months of death)

Major findings of operations LDate of op. LAutopsy results L

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide L Date of L

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) LMens of injury Injured at work? L23. SIGNATURE Harry M. Hodgson M.D.
M. D. or otherAddress Lancaster, Md Date signed June 6 47

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JUN 20 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

04655

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

707 Sylvan Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 707 Sylvan Ave
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

George Schade

3. (b) Social Security Number

220-07-6130

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Anna E. Snyder

6. (c) If alive, give age 70 years

7. Birth date of

deceased (mo., day, yr.)

Oct 14, 1871

8. AGE:

Years 75 Months 7 Day 27 If less than one day .hrs. min.

9. Birthplace Cumberland Allegany Co. Md
(Town, county, and state)

10. Usual occupation Glass Worker

11. Industry or business Queen Glass Co.

12. Name George Schade

13. Birthplace Germany

14. Maiden name Wick

15. Birthplace Wicktown

16. Informant Mrs. George Schade

Address 707 Sylvan Ave, Cumberland, Md

17. Burial Date thereof June 14, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland Md

18. Funeral director John J. Hafin

Address Cumberland Md

19. June 14 19 47 J. P. Baukhuis, M. D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 47 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above elated; that I attended deceased from

Sept. 15 19 40 to June 11 19 47

and that I last saw him alive on March 10 19 49

Immediate cause of death

Cervical Throat

DURATION

Due to

Due to

Other conditions Hypertension 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Snyder M. D. or other

Address Cumberland Md (Date signed 6-17-47)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUN 18 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04656

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33-5-13

Hospital, institution, or street address where death occurred:

418 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 418 Fayette St.
(If rural, give LOCATION)2.(a) If veteran, name war II World War

3. (a) FULL NAME

Hugh MacMullen Shaffer

3. (b) Social Security Number

714-05-79824. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 2 19148. AGE: Years 33 Months 5 Days 13 It less than one day

6.(c) If alive, give age..... years

9. Birthplace Cumberland Ind.
(Town, county, and state)10. Usual occupation Officer U. S. Marine11. Industry or business Retired12. Name Luther P. Shaffer13. Birthplace Ind.14. Maiden name Bary MacMullen15. Birthplace Ind.16. Informant Luther ShafferAddress Cumberland17. Burial Date thereof June 18 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter & Pauls ConLocation Cumberland Ind.18. Funeral director Gomis Stein IncAddress Cumberland19. June 17 19 47 Winter P. Frantz, M.D.
(Date rec'd by registrar) (month) (day) (year) Acting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 47 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1st 19 47 to 6-15-47 19and that I last saw him alive on 4-27-47 19

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. P. FrantzAddress Cumberland Ind. Date signed 6-16-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

04657

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Chamberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, institution, or street address where death occurred: Allegany Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Allegany
 City or town Chamberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5027 Mechanic St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

Clark Edward Shanholtz

3. (b) Social Security Number

217-10-1469

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ethel Frost
 6. (c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.) June 30, 1884
 8. AGE: Years 62 Months 11 Days 12 If less than one day
 hrs. min.

9. Birthplace Hampshire County, W. Va.
 10. Usual occupation Machinist Help Co.
 11. Industry or business Celausene Corp.
 12. Name Peter Shanholtz
 13. Birthplace Coldstream, W. Va.
 14. Maiden name Unknown
 15. Birthplace

16. Informant Mrs. Ethel Shanholtz
 Address 5027 Mechanic St. Chamberland, Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 14, 1947
 (month) (day) (year)
 Cemetery or crematory First Lutheran Cemetery
 Location Chamberland, Md.
 18. Funeral director John J. Hafer
 Address Chamberland, Md.
 19. (Date rec'd by registrar) June 14, 1947 J. P. Kanhu, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947 at 9:50 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 47 to June 47
 and that I last saw him alive on June 12, 1947
 Immediate cause of death nephritis, chronic DURATION 3 yrs
 Due to
 Due to
 Other conditions Myocarditis
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, till in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE R. W. Hewaskis, Jr. MD
 Address Chamberland, Md. Date signed 6/12/47
 M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Alligany
City or town Flintstone (Star Route)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Alligany
City or town Flintstone (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Star Route
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Edward Burgess Shipway

3. (b) Social Security Number

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ella K Shipway
6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 11 1879

8. AGE: Years 68 Months 13 Days 13 It less than one day hrs. min.

9. Birthplace Fulton Co Pa
(town, county, and state)

10. Usual occupation Laborer (retired)

11. Industry or business

12. Name Richard Shipway

13. Birthplace Pa

14. Maiden name Isabel Patten

15. Birthplace Pennsylvania

16. Informant John T Shipway

Address Flintstone Md

17. Burial Date thereof June 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview cemetery

Location Artemus, Pa (rural) Bedford Co

18. Funeral director Ephraim Smith

Address Artemus Pa

19. June 26 19 47 Nina L. Bender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 47 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 19 47 to June 25 19 47
and that I last saw him alive on June 25 19 47

Immediate cause of death Cerebral hemorrhage DURATION 14 hrs.

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Watson M.D.
M. D. or other

Address Baltimore Md Date signed 6/25/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

JUN 27 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1316 not CB

04659

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegheny
 City or town Fort Wayne
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos.
 Hospital, institution, or street address where death occurred:
Miner's Hospital
 How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind. County Wayne
 City or town Bethel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1317 Leyscastle Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Ralph Switzer

3. (b) Social Security Number

363-10-5576

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 11 - 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

48

11

10

hrs.

min.

9. Birthplace

Greene, Ind.
 (Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

Hudson Motor Co

MOTHER FATHER

12. Name

George W. Switzer

13. Birthplace

Zehlman, Ind.

14. Maiden name

Harry Cannegans

15. Birthplace

Leitch, Indiana, Ind.

16. Informant

Joseph E. Switzer

Address

73 1/2 St. Fraternity, Ind.

17.

Burial

Date thereof

6-24-1947

Cemetery or crematory

St. Michael's Cem.

Location

Fort Wayne, Ind.

18. Funeral director

Joseph E. Switzer

Address

Fort Wayne, Ind.

19.

6-24

19

47

Chanelle C. Bruce

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 21 1947 at 10:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1947 to June 21 1947

and that I last saw him alive on June 21 1947

Immediate cause of death

Chronic Nephritis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

WOM Lane

M. D. or other

Address

Fort Wayne, Ind.

Date signed 6-23-47

RECEIVED

JUN 26 1947

BUREAU V C

DR WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 04660 4

1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 12 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY

City or town.....~~CUMBERLAND~~
(If outside city or town limits, write RURAL and give nearest town)Street No.....CRESAPTOWN MD.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Boy Skelley

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE

WHITE

NEW BORN

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) June 3, 1947

8. AGE: Years Months Days If less than one day
12 hrs. 50 min.9. Birthplace Cumberland Allegany Co., Md.
(Town, County, and State)

10. Usual occupation.....

11. Industry or business.....

12. Name.....SKELLEY, JAMES

13. Birthplace MARYLAND

14. Maiden name.....STOTTLER, ETHEL

15. Birthplace MARYLAND

16. Informant.....Memorial Hospital

Address.....Cumberland, Md.

17. Burial, cremation, or removal. Which? Date thereof June 4, 1947
(month) (day) (year)

Cemetery or crematory.....Memorial Hosp.

Location.....Cumberland, Md.

18. Funeral director.....Same as above

Address.....

19. June 17, 1947 Dr. Peter R. Trantz, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....4 June 1947 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 June 1947, to 4 June 1947

and that I last saw him alive on 4 June 1947

Immediate cause of death Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....Dwight B. Whitworth

M. D. or other

Address.....112 Bedford St. - Date signed 5 June 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1947
BUREAU V B

RECEIVED
JUN 18 1947
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

04661

DR. ENFIELD

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs.
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 607 WASHINGTON STREET
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DIXON CONLEY SLOAN

3. (b) Social Security Number

714-05-4493

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) NOVEMBER 8, 1895 6.(c) If alive, give age _____ years

8. AGE: Years 50 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace INDIANA
 (Town, county, and state)

10. Usual occupation GLASS MANUFACTURER

11. Industry or business

12. Name MATHEW SLOAN13. Birthplace MARYLAND14. Maiden name CONLEY, VIRGINIA15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND

17. Burial Date thereof June 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cem.Location Frostburg, Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.

19. June 17, 1947 Walter R. Faulk, M.D.
 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 15, 1947 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 to June 15 and that I last saw him alive on June 15

Immediate cause of death

Respiratory failure
due to
asphyxia
due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. June 14

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Faulk M. D. or otherAddress Cumberland Date signed 6/10/47

RECEIVED

JUN 24 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04662

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Barton-Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Barton-Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 1/2 Mi. South of Barton
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Nathern Smith

3. (b) Social Security Number

220-07-6581

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sarah Trenum Smith6. (c) If alive, give age 50 years7. Birth date of deceased (mo., day, yr.) Aug 9, 18868. AGE: Years 60 Months 10 Days 20 If less than one day
hrs. min.9. Birthplace Luray-Page-Virginia
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Paper-Mill12. Name Thomas Smith13. Birthplace Virginia14. Maiden name Jane Price15. Birthplace Virginia16. Informant Mrs Joseph SmithAddress Barton, Md.17. Burial Date thereof July 2, 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Philos Cem.Location Westernport18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. July 2 1947 Ellsworth S. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 7.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/27 to 6/29 and that I last saw him alive on 6/29/47

Immediate cause of death

Ch. Myocarditis

DURATION

7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

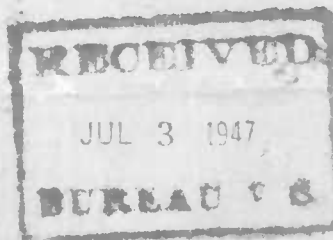
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Ellsworth S. Boal M. D. or otherAddress Westernport, Md. Date signed 7/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04663

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Chamberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred 824 Harvard Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Chamberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 824 Harvard Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Jelda Stein

3. (b) Social Security Number

None

4. Sex Female 5. Color of race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Alex Stein

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884 ?

8. AGE: Years 63 Months ? Days If less than one day hrs. min.

9. Birthplace Russia
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Harry Stein

Address Chamberland Ind.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof June 20 47
 (month) (day) (year)

Cemetery or crematory East Gate Cem.

Location Chamberland

18. Funeral director Louis Stein Inc

Address Chamberland

19. June 20 47 White R. Trautman, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to June 18 1947

and that I last saw him/her alive on June 10 1947

Immediate cause of death 1) Pulmonary embolism (massive) or

2) Coronary occlusion

Due to Fracture left femoral neck sustained

Due to

Other conditions Hypertensive C-V Disease years
Atherosclerosis years
 (Include pregnancy within 3 months of death)

Major findings of operations Osteotomy of left femur (non-union) Date of op. 10-12-46

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 6-1-46

Where did injury occur? Chamberland Alleg. Ind.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell at home Injured at work? No

23. SIGNATURE A. Smickin Ind.
 M. D. or other

Address 115 S. Centre St Date signed 6-19-47
Chamberland Ind.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1947
BUREAU OF

DR. HO DGES MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04664

159

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County CUMBERLANDCity or town _____
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 521 FAYETTE ST.

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BABY GIRL STRIDEPREMATURE INFANT

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

JUNE 23, 1947

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7

hrs. min.

9. Birthplace

CUMBERLAND, ALLEGANY CO., MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

HUGH STRIDE

13. Birthplace

PA. Philadelphia

14. Maiden name

AUDREY JOLLEY

15. Birthplace

MD. Allegany County

16. Informant

Address

17. Burial
(Burial, cremation, or removal, Which?)

Date thereof

July 1, 1947
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 1, 1947
(Date rec'd by registrar)Walter R. Truby, M.D.
Registrar

MEDICAL CERTIFICATION

JUNE 29, 19475:32 A.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 23 1947 to June 29 1947

and that I last saw him alive on June 28 1947

Immediate cause of death

Premature twin
(7 months)

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

W. R. Hodges M.D.
Cumberland, Md.
Date signed 6/30/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1947

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

04665

4

DR SCHINDLER

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 207 Fifth St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Clara Taylor

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Jacob Taylor
 7. Birth date of deceased (mo., day, yr.) November 1, 1865
 8. AGE: Years 81 Months 7 Days 4 If less than one day
 .. hrs. min.

9. Birthplace Illinois
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Charles Ely
 13. Birthplace Illinois
 14. Maiden name Margaret Shelly
 15. Birthplace Stoughton, Va.

16. Informant Enzo C. Dorsey

Address 434 Loing Ave., Cumberland, Md

17. Burial Date thereof June 7, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director John J. Walker

Address Cumberland, Md

19. June 6, 1947 J. P. Frankhu, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1947, to June 5 1947
 and that I last saw him alive on June 4 1947

Immediate cause of death Bronchopneumonia DURATION 10 days

Due to Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M. or other

Address 41 Emerald Date signed June 5, 1947

RECEIVED

JUN 11 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 3 HOURS 5 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 951 BRADDOCK RD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EDITH L. TAYLOR

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOW6. (b) Name of husband or wife RICHARD TAYLOR

6. (c) If alive, give age. years

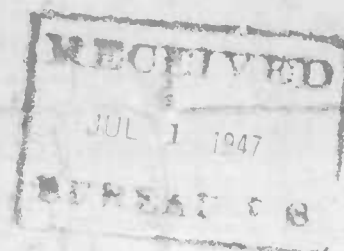
7. Birth date of deceased (mo., day, yr.) SEPT 2, 18708. AGE: Years 76 Months 9 Days 25 If less than one day hrs. min.9. Birthplace LONDON ENGLAND
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name MEYERS HARRY13. Birthplace ENGLAND14. Maiden name LOWESBY FANNIE15. Birthplace ENGLAND16. Informant Mrs. Albert W. KeightAddress 951 Braddock Rd. Cumberland, Md.17. Burial Date thereof June 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director H. Wayne GeorgeAddress Cumberland, Md.19. June 28, 47 White R. Fautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-27 1947 to 6-27 1947and that I last saw him alive on 6-27-47 1947Immediate cause of death Ant. Arteriosclerotic DURATIONPneumoniaObd. Cor. Artery23. SIGNATURE W. H. Fautz M. D. or otherAddress White R. Fautz, M.D. Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95a

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 years
 Hospital, institution, or street address where death occurred:
19 South Centre St.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 19 South Centre St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

Zela Catherine Underbank

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Charles F. Underbank
 6.(c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) 5 July 1867

8. AGE: Years 79 Months 11 Days 14 It less than one day — hrs. — min.

9. Birthplace Shirpsburg, Maryland
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business —

FATHER 12. Name Henry Johnson

13. Birthplace Shirpsburg, Md.

MOTHER 14. Maiden name unknown

15. Birthplace —

16. Informant Mrs. Walter Neff

Address 318 Cumberland St., Cumberland, Md.

17. (Burial, cremation, or removal. Which?) burial Date thereof June 21, 1947
 (month) (day) (year)

Cemetery or crematory Citizen's Cemetery

Location Shirpsburg, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. June 21, 1947 Winters R. Traub, M.D. Registrar
 (Date rec'd by registrar) acting

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 47 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-19-47 19 47 to 6-19-47 19 47
 and that I last saw her alive on 6-18-47 19 47

Immediate cause of death Arteriosclerotic fibrillation DURATION 1 mo.

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Manner of injury — Injured at work? —

23. SIGNATURE Winters R. Traub, M.D. M. D. or other

Address Cumberland, Md. Date signed 6-20-47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Zimm 04667

RECEIVED

JUN 24 1947

BUREAU VS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

04668

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Prosthersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Miller Mine near Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) ✓
2. (a) If veteran, name war.

3. (a) FULL NAME

Miss Clara Miller Pragus

3. (b) Social Security Number

✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife James Pragus
6. (c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.) April 1, 1868

8. AGE: Years 79 Months 2 Days 29 If less than one day ✓ hrs. ✓ min.

9. Birthplace Smiths Int. near Midland Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name Henry Miller

13. Birthplace Smiths Int. near Midland, Md

14. Maiden name Dickey

15. Birthplace Albion, N.Y.

16. Informant Mrs. Helen Loar

Address Midland, Md

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof July 2, 1947
(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Prosthersburg, Md.

18. Funeral director Wm. Spickhorn

Address Lawsoning, Md

19. 6-30 47 Wm. Nancy N. Rae
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47 at 12¹⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 19 47 to June 30 19 47

and that I last saw her alive on June 29 19 47

Immediate cause of death Fracture RT Hip

DURATION

10 Day

Due to arterio sclerosis

Due to Senility

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of June 20 1947

Where did injury occur? Midland (City or town) Alleg (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Mens of injury Fell Injured at work? no

23. SIGNATURE Wm. Spickhorn

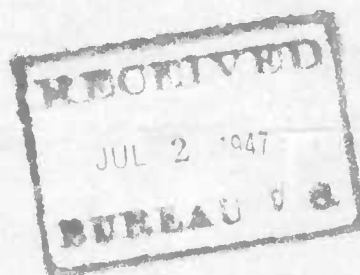
Address Prosthersburg, Md Date signed 6-30-47

MARGIN RESERVED FOR BINDING

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VS A15 9-25-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04672

1. PLACE OF DEATH:

County Allegheny
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Other life
Hospital, institution, or street address where death occurred:
mine's Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pa. County Allegheny
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Louisa Patterson Wisentore

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Henry Wisentore
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 30th. 1885

8. AGE: Years 61 Months 7 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Eastport, Allegheny, Pa.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James M. Wisentore

13. Birthplace Eastport, Pa.

14. Maiden name Miss Jameson

15. Birthplace Eastport, Pa.

16. Informant Mrs. David Robinson

Address 18 Bialoo Lane Frostburg

17. Burial Date thereof 6-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Portia Cemetery

Location Eastport, Pa.

18. Funeral director Geoff Hofer

Address Frostburg, Md.

19. 6-28 1947 Blanche D. Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-17 1947 to 6-26 1947
and that I last saw her alive on 6-26 1947

Immediate cause of death Arteriosclerotic Heart disease
Spasm of Cerebral artery causing
Due to thrombus, due to acute
gastro-enteritis
Due to acute exacerbation of
chronic tonsillitis

DURATION

3 yrs.

24 hrs

50 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank T. Harak md.

Address 59 E. Main St. Frostburg M. D. or other _____

Date signed 6-27-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 30 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 04069

1. PLACE OF DEATH:

County Allegany
City or town rural) Pinto Lane
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Rural) Pinto Lane
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Cresaptown Md.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Charles A. Wertz

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Elizabeth Shultz Wertz

7. Birth date of deceased (mo., day, yr.) Jan. 26 -1869 6. (c) If alive, give age.....years

8. AGE: Years 78 Months 4 Days 17 If less than one day.....hrs.min.

9. Birthplace Bedford Co., Penna.
(Town, county, and state)

10. Usual occupation Retired
11. Industry or business State Roads Commission

12. Name Emanuel Wertz
13. Birthplace Penna.

14. Maiden name Ella Zimmerly
15. Birthplace Penna.

16. Informant Mrs. Marshall McKenzie
Address R.D. #5 Box 391 Cumberland, Md.

17. Burial Date thereof June 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Pinto Cem.
Location Pinto, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. 6/16/47 19. [Signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 47 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him Dead June 13 19 47

Immediate cause of death Carcinoma of the face DURATION several years

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. [Signature]
Address Cumberland Md Date signed 6/16/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 18 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04670

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Midlothian
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 55 years
 Hospital, institution, or street address where death occurred:
Midlothian, Ind.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Ind. County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Midlothian
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Julia Anne Willette

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Frank Willette
 7. Birth date of deceased (mo., day, yr.) Aug. 26th 1883 6.(c) If alive, give age 55 years

8. AGE: Years 63 Months 9 Days 21 If less than one day hrs. min.

9. Birthplace Borden, Ind. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Mathew Skidmore

13. Birthplace England

14. Maiden name Janet Bone

15. Birthplace

16. Informant Miss Kate Willette

Address Midlothian, Ind.

17. Burns Date thereof 6-30-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Ind.

18. Funeral director Janet Bone

Address Frostburg, Ind.

19. 6-18 19 47 Ms. Nancy N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 19 47 at 2:10 M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to June 17 19 47
 and that I last saw her alive on 6/16 19 47

Immediate cause of death Hypertensive Heart Disease DURATION 6 months
Coronary occlusion 2 hrs

Due to
 Due to
 Other conditions Intestinal Grippe 4 days
 (Include pregnancy within 3 months of death)

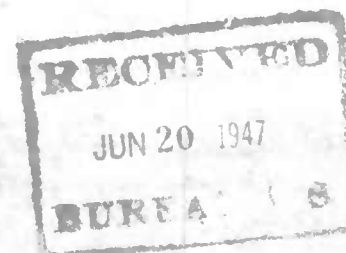
Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Hilda Jurek, M.D. M. D. or other
Frostburg, Ind. Address Date signed 6/17/47



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 046714

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 4½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 55 Boone St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Bradford Wilson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed6.(b) Name of husband or wife Nellie Williams

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 18808. AGE: Years Months Days If less than one day
66 7 24 hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Salesman

11. Industry or business

12. Name Simon Wilson
13. Birthplace Maryland14. Maiden name Emma Fisher
15. Birthplace Maryland16. Informant Mr. Simeon T. Wilson
Address 55 Boone St. Cumberland, Md.17. Burial Date thereof June 11, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.
Cumberland, Md.
Location18. Funeral director Charles L. George
Address Cumberland, Md.19. June 11, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

220-16-6954

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/4/47 1947 to 6/9/47 1947
and that I last saw him alive on 6/9/47

Immediate cause of death

Myocardial Failure DURATION 5 yrsDue to Chr Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

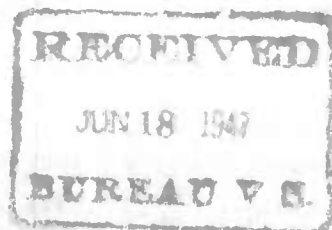
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Williams M.D. M. D. or otherAddress Cumberland, Md. Date signed 6/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

Reg. Dist. No. 04673/

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 58 yrs
 Hospital, institution, or street address where death occurred:
715 Schriver Ave.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 715 Schriver Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

J. Frank Young

3. (b) Social Security Number

720-07-6773

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Gertrude Henkel
 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) 4 October 1888

8. AGE: Years 58 Months 7 Days 28 If less than one day — hrs. — min.

9. Birthplace Cumberland Allegany Co. Md.
 (Town, county, and state)

10. Usual occupation Roofman

11. Industry or business City Engineering Dept.

12. Name William Young

13. Birthplace Md.

14. Maiden name Fannie Harrison

15. Birthplace Md.

16. Informant Franklin Young

Address 715 Schriver Ave. Cumberland Md.

17. Burial, cremation, or removal (Which?) Burial Date thereof June 5, 1947
 (month) (day) (year)

Cemetery or crematory St. Luke's Cemetery

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. June 5 19 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 June 19 47 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 March, 19 47, to 2 June 19 47
 and that I last saw him alive on 29th of May 19 47

Immediate cause of death Carcinoma of the lung with generalized carcinomatosis

DURATION

8 mos.

Due to Coronary heart disease 2 yrs.

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W. Alfred Van Ormer M. D. or other

Address 110 S. Centre St. Date signed 4 June,

1947

RECEIVED

JUN 11 1947

BUREAU OF